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| Filled in by: |  | | | | | | | | | | | | Contact number: | | | | | | | | | | (000) 000 0000 | | | | | | | | |
| Date: | DD / MM / YYYY | | | | | | | | | | | | Information collected from: | | | | | | | | | |  | | | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. SURNAME, FIRST NAME: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. AGE/DOB | | 00 | years | | | | / | DD / MM / YYYY | | | | | 3. GENDER:  MALE  FEMALE | | | | | | | | | | | | | | | | | | |
| 4. CONTACT NUMBER: | | | | | | (000) 000 0000 | | | | | (000) 000 0000 | | | | | | | (000) 000 0000 | | | | | | | | | | | | | |
| 5. OCCUPATION: | | |  | | | | | | | | | | | | 6. FARM NAME: | | | | |  | | | | | | | | | | | |
| 7. TOWN: |  | | | | | | | | | | DISTRICT: | | | | | |  | | | | | | | PROVINCE: | | | | | |  | |
| **CONSULTATION/ADMISSION DETAILS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. NAME CLINICIAN: | | | |  | | | | | | | | | 9. CELL/TEL NUMBER: | | | | | | | | | (000) 0000000 | | | | | | | (000) 0000000 | | |
| 10. FACILITY NAME: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. DATE OF FIRST CONSULTATION: | | | | | | | | | DD / MM / YYYY | | | | | 12. SPECIMEN COLLECTION DATE: | | | | | | | | | | | | | DD / MM / YYYY | | | | |
| 13. ADMITTED TO HOSPITAL?  Y  N | | | | | | | | | | | | | | | | 14. REQUIRED ICU CARE?  Y  N | | | | | | | | | | | | | | | |
| If yes, DURATION OF HOSPITAL ADMISSION? | | | | | | | | | | | 00 | (days) | | | | If yes, DURATION OF ICU CARE? | | | | | | | | | | | | 00 | | (days) | |
| **CLINICAL DETAILS ON FIRST PRESENTATION/ADMISSION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **15. PAST MEDICAL HISTORY:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| UNDERLYING ILLNESS? | | | | | | Y  N | | | | … If yes, WHAT? | | | | | | | | |  | | | | | | | | | | | | |
| IMMUNOSUPPRESSION? | | | | | | Y  N | | | | … If yes, GIVE DETAILS? | | | | | | | | |  | | | | | | | | | | | | |
| PAST RVFV INFECTION? | | | | | | Y  N | | | | … If yes, WHEN? | | | | | | | | | 00 | | (month) | | | | | 0000 | | | | | (year) |
| **16. DATE OF ONSET OF ILLNESS?** DD / MM / YYYY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **17. SYMPTOMS (tick all that apply)**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FEVER  MYALGIA  ARTHRALGIA  FATIGUE  MALAISE  LOSS OF APPETITE  NAUSEA  VOMITING | | | | | | ABDOMINAL PAIN  NECK STIFFNESS  HEADACHE  OCULAR PAIN  PHOTOPHOBIA  BLURRED VISION  LOSS OF VISUAL ACUITY  CONFUSION | | | | | | | | **18.**  **HAEMORRHAGE (If yes, tick sites that apply):** | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | | EPISTAXIS  HAEMATEMESIS  MELAENA  MENORRHAGIA | | | | | | | PETECHIAE BLEEDING  FROM VENEPUNCTURE SITES | | | | | | | | | | |
|  | | | | | |  | | | | | | | | BLEEDING ELSEWHERE? Specify: | | | | | | | | | | | | | | | | | |
|  | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **19. EXAMINATION ON PRESENTATION (tick all that apply):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| FEVER (≥ 38°C)  SHOCK (↓BP) | | | | | | DEHYDRATION  JAUNDICE  PALLOR | | | | | | | | MENINGISM  CONFUSION  RETINITIS | | | | | | | HEPATOMEGALY  ABDOMINAL TENDERNESS  RASH | | | | | | | | | | |
| **20. LIST OTHER CLINICAL FINDINGS?** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **21. CLINICAL PROGRESSION TO DATE?**  UNEVENTFUL RECOVERY or  DEVELOPED COMPLICATIONS ... If developed complications, tick all that apply: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ELEVATED TRANSAMINASE LEVELS (AST, ALT)  LIVER FAILURE  RENAL FAILURE | | | | | | | | | | | | | | | THROMBOCYTOPENIA  HAEMORRHAGE | | | | | | | | | | RETINITIS  ENCEPHALITIS | | | | | | |
| **22. OUTCOME:**  ALIVE  DIED … If yes, DATE OF DEATH? | | | | | | | | | | | | | | | | | | DD / MM / YYYY | | | | | | | | | | | | | |
| **23. EXPOSURE (tick all that apply)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DATE OF EXPOSURE? | | | | | DD / MM / YYYY | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTACT WITH ANIMALS/ TISSUES  MOSQUITO BITES | | | | | | | | | | DRANK UNPASTEURISED MILK  CONSUMED ANIMAL MEAT NOT SOURCED FROM RETAIL OUTLET | | | | | | | | | | | | | | | | | | | | | |
| DESCRIPTION OF EXPOSURE: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

# RIFT VALLEY FEVER SUSPECTED CASE INVESTIGATION FORM, 2021